

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 13, 14 Film G377 6/10/66 mh

**08518**

## CERTIFICATE OF DEATH

**08508**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>HOWARD</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKRIDGE</b>		c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKRIDGE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6801 WASHINGTON BOULEVARD 21227</b>		d. STREET ADDRESS <b>6801 WASHINGTON BOULEVARD</b>	
<b>3. NAME OF DECEASED</b> (Type or print)      First      Middle      Last <b>ARTHUR      B.      CROOK</b>		<b>4. DATE OF DEATH</b> Month      Day      Year <b>JUNE      3,      19 66</b>	
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <b>10-27-1900</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>BUILDER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>  	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>  	
<b>13. FATHER'S NAME</b> <b>James W. Crook</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary E. Quinn</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>217-07-6718</b>	
<b>17. INFORMANT</b> Address <b>MRS. MARGARET W. CROOK, 6801 WASHINGTON BLVD</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Car of Tongue</u> 1419 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m.      p.m.      19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20d. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  	
<b>20e. (City or town)</b> (County) (State)  			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>60</u> to <u>2 JUNE</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2 JUNE</u> , 19 <u>66</u> , and that death occurred at <u>12:57 PM</u> , from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>George E. Groleau</u> M.D.		<b>22b. DATE SIGNED</b> <u>4 June 66</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>GEORGE E. GROLEAU</b>		<b>22d. ADDRESS</b> <b>5806 MAIN STREET-ELKRIDGE</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>6-6-66</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>ST. AUGUSTINE'S CEMETERY</b>		<b>23d. LOCATION</b> (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>HOWARD H. HUBBARD, 4107 WILKENS AVENUE 21229</b>		<b>25a. REC'D BY REGISTRAR</b> DATE <b>JUN 7 1966</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <div style="text-align: center;"><b>Howard</b></div> <div style="text-align: right;"><b>MARYLAND</b></div>					<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> <b>a. STATE</b> <div style="text-align: center;"><b>Maryland</b></div> <div style="text-align: right;"><b>Howard</b></div>				
<b>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <div style="text-align: center;"><b>Ellicott City</b></div>					<b>c. LENGTH OF STAY IN 1b</b> <div style="text-align: center;"><b>Ellicott City</b></div>				
<b>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</b> <div style="text-align: center;"><b>Ilchester Road</b></div>					<b>d. STREET ADDRESS</b> <div style="text-align: center;"><b>Ilchester Road</b></div>				
<b>3. NAME OF DECEASED (Type or print)</b> <div style="text-align: center;"><b>MARTHA JANE FAY</b></div>					<b>4. DATE OF DEATH</b> <div style="text-align: center;"><b>June 30, 1966</b></div>				
<b>5. SEX</b> <div style="text-align: center;"><b>Female</b></div>		<b>6. COLOR OR RACE</b> <div style="text-align: center;"><b>White</b></div>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <div style="text-align: center;"><b>WIDDED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></div>		<b>8. DATE OF BIRTH</b> <div style="text-align: center;"><b>Sept. 15, 1876</b></div>		<b>9. AGE (In years last birthday)</b> <div style="text-align: center;"><b>89 yrs.</b></div>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <div style="text-align: center;"><b>At home</b></div>					<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <div style="text-align: center;"><b>Pennsylvania</b></div>				
<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <div style="text-align: center;"><b>Pennsylvania</b></div>					<b>12. CITIZEN OF WHAT COUNTRY?</b> <div style="text-align: center;"><b>Pennsylvania</b></div>				
<b>13. FATHER'S NAME</b> <div style="text-align: center;"><b>Leonard</b></div>					<b>14. MOTHER'S MAIDEN NAME</b> <div style="text-align: center;"><b>Frank Fay, Ilchester Road, Ellicott City, Md</b></div>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> <div style="text-align: center;"><b>No</b></div>					<b>16. SOCIAL SECURITY NO.</b> <div style="text-align: center;"><b>None</b></div>				
<b>17. INFORMANT</b> <div style="text-align: center;"><b>Frank Fay, Ilchester Road, Ellicott City, Md</b></div>					<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <div style="text-align: center;"><b>Cardiac failure</b></div>				
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <div style="text-align: center;"><b>7834</b></div>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <div style="text-align: center;"><b>96 hrs.</b></div>				
<b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <div style="text-align: center;"><b>DUE TO</b></div>					<b>(c)</b> <div style="text-align: center;"><b>DUE TO</b></div>				
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>									
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>					<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>				
<b>20c. TIME OF INJURY</b> Month, Day, Year <div style="text-align: center;"><b>19</b></div>					<b>20d. INJURY OCCURRED</b> <div style="text-align: center;"><b>While at work</b> <input type="checkbox"/> <b>Not while at work</b> <input type="checkbox"/></div>				
<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>					<b>20f. (City or town) (County) (State)</b>				
<b>21. I certify that (I) (this hospital) attended the deceased from <u>10-28, 1960</u>, to <u>6-30, 1966</u>, that (II) (we) last saw the deceased alive on <u>6-27, 1966</u>, and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <div style="text-align: center;"><b>Thomas F. Herbert, M.D.</b></div>					<b>22b. DATE SIGNED</b> <div style="text-align: center;"><b>7-1-66</b></div>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <div style="text-align: center;"><b>Thomas F. Herbert, M.D.</b></div>					<b>22d. ADDRESS</b> <div style="text-align: center;"><b>44 Church Rd., Ellicott City, Md</b></div>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <div style="text-align: center;"><b>Burial</b></div>					<b>23b. DATE THEREOF</b> <div style="text-align: center;"><b>7-5-1966</b></div>				
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <div style="text-align: center;"><b>Rehobeth</b></div>					<b>23d. LOCATION (City, town or county) (State)</b> <div style="text-align: center;"><b>Pricedale, Pa.</b></div>				
<b>24. FUNERAL DIRECTOR</b> <div style="text-align: center;"><b>F.C. Miginbothom</b></div>					<b>25a. REC'D BY REGISTRAR</b> <div style="text-align: center;"><b>JUL 5 1966</b></div>				
<b>25b. REGISTRAR'S SIGNATURE</b> <div style="text-align: center;"><b>Charles Judge</b></div>					<b>25c. REGISTRAR'S SIGNATURE</b> <div style="text-align: center;"><b>Charles Judge</b></div>				

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
08520					CERTIFICATE OF DEATH					08510				
1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rt. 3</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Rt. 3</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EDITH</b> Last <b>FOX</b>					4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1966</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-5-1881</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>13</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>19</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country) <b>Howard Co., Md</b>				
13. FATHER'S NAME <b>B. Franklin Keyes</b>					14. MOTHER'S MAIDEN NAME <b>Annie Sykes</b>					12. CITIZEN OF WHAT COUNTRY?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>					17. INFORMANT <b>Charles C. Fox, Rt. 3, Ellicott City, Md</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crown Thrombosis</b> DUE TO (b) <b>Atherosclerotic cardio-</b> cause (a), stating the underlying cause last. (c) <b>vascular dis.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>week</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town) (County) (State)					21. I certify that (I) (this hospital) attended the deceased from <b>August 19, 1963</b> to <b>June 22, 1966</b> that (I) <del>last</del> saw the deceased alive on <b>June 22, 1966</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Charles C. Fox</b>					22b. DATE SIGNED <b>6/23/66</b>					22c. PHYSICIAN'S NAME (Type) <b>BALTIMORE NAT'L. PIKE &amp; ST. JOHN'S LANE ELICOTT CITY, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>6-25-1966</b>					23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>				
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>					25a. REC'D BY REGISTRAR <b>JUN 27 1966</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 7/61

**M**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

08521

08511

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessup</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Guilford Road</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jessup</b> d. STREET ADDRESS <b>Guilford Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <b>MELVIN RUBIN KNISLEY</b> First Middle Last			<b>4. DATE OF DEATH</b> <b>JUNE 16</b> Month Day Year <b>1966</b>		
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1900</b> <b>August 23, 1900</b>	<b>9. AGE</b> (In years last birthday) <b>65</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>general construction</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Virginia</b>	
<b>13. FATHER'S NAME</b> <b>David Rubin Knisley</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Daisey Holmes</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mary L. Knisley, Guilford Road, Jessup, Md</b> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>161X</b> DUE TO <b>1. Hemiplegia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic ca. involving trachea</b> DUE TO <b>2. Carcinoma larynx</b> (c) <b>Metastatic carcinoma - lungs.</b>					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 yr. 3 gr.</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Metastatic carcinoma - lungs.</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from 10/15, 1963 to 6/16, 1966, that (I) (we) last saw the deceased alive on 6/16, 1966, and that death occurred at M, from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <b>Robert G. Chambers</b> <b>22c. PHYSICIAN'S NAME</b> (Type)			<b>22b. DATE SIGNED</b> <b>836 Park Ave. Baltimore, Md.</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>June 20, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Savage Cemetery</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>De Witt Dandelion Laurel Md</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>		<b>25a. REC'D BY REGISTRAR</b> <b>JUN 27 1966</b>	

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4380



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08522

08512

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Simpsonville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Simpsonville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Freetown Road, Box 34</b>		d. STREET ADDRESS <b>Freetown Road, Box 34</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Deborah Denice Kosh</b>		4. DATE OF DEATH Month Day Year <b>June 20 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1966</b>
9. AGE (In years last birthday) yrs. <b>4Mths</b>		IF UNDER 1 YEAR Days Hours Min. <b>4Mths</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Irvin Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Delores Kosh</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Delores Kosh</b>		Address <b>Same as item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Oriris Media bilateral</b> 3912 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>June 20, 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>6/22/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hopkins Chapel</b>	23d. LOCATION (City or Town) (County) (State) <b>Highland, Md.</b>
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b> Rockville, Md.		25a. BY REGISTRAR <b>JUN 23 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

NI 100

SS200

Original document 200 0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

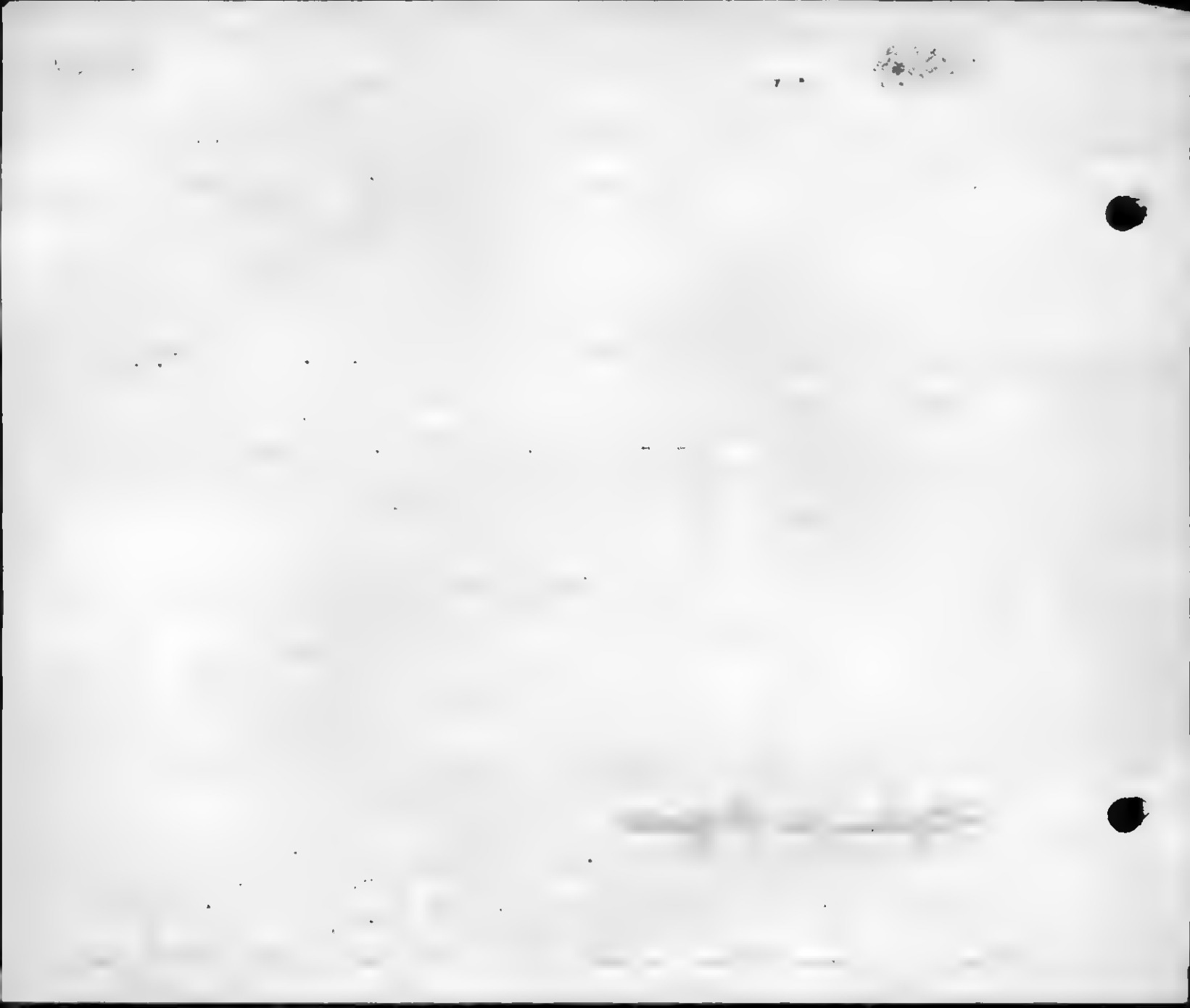
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

08523

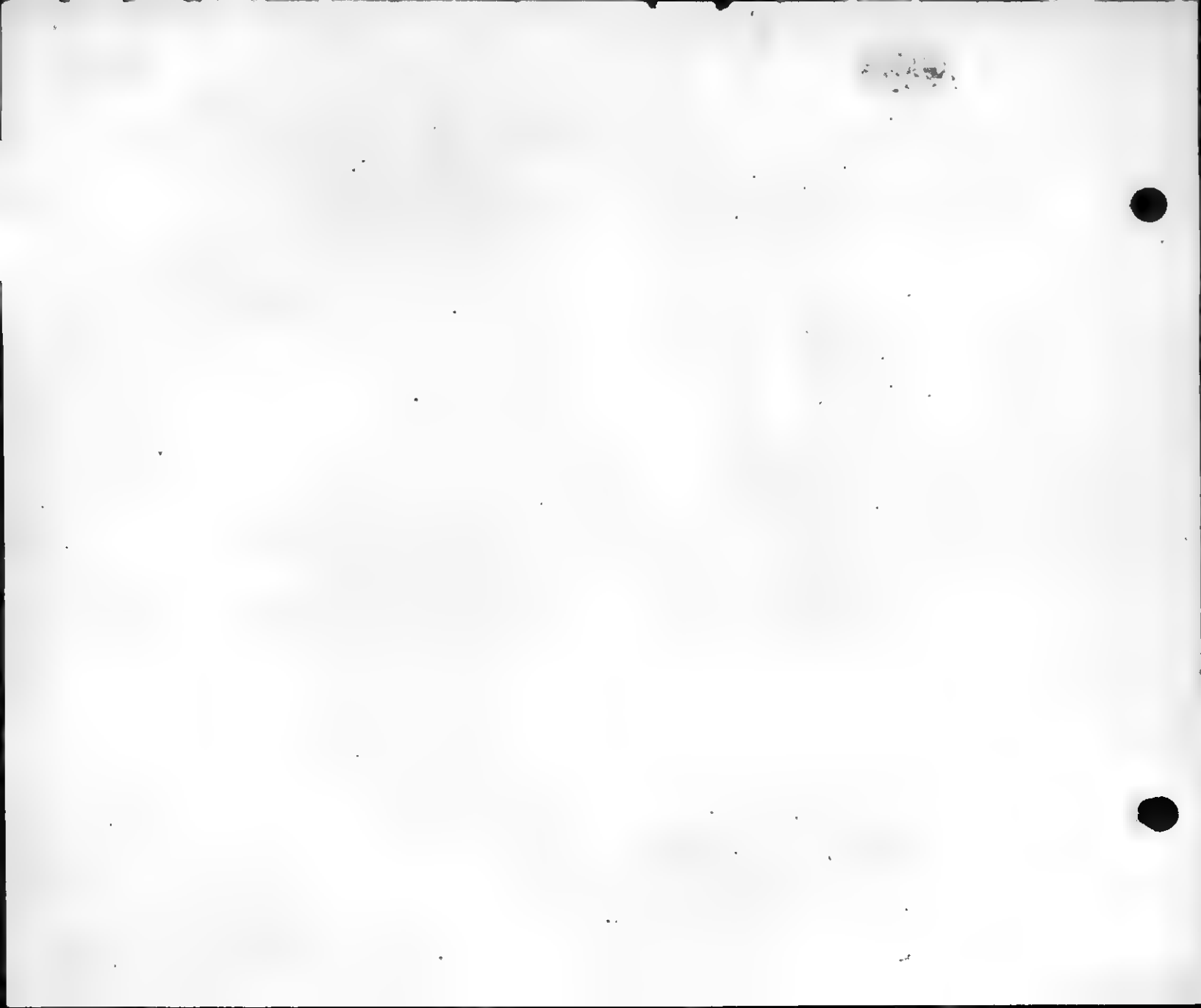
08513

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HOWARD</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLCOTT CITY</u> c. LENGTH OF STAY IN b. <u>ELLCOTT CITY</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>TAYLOR MANOR HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>5713 Edmondson Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>LOUIS</u> <u>PHILIP</u> <u>KRAUS</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>JUNE</u> <u>20</u> <u>19 66</u>	
<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>8-6-93</u> <b>9. AGE</b> (In years last birthday) <u>72</u> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGENT</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>BALTIMORE, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Ernest Kraus</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Bertha Mohlenhich</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>World War I</u> <b>16. SOCIAL SECURITY NO.</b> <u>216-28-5845</u> <b>17. INFORMANT</b> <u>Mrs. Catherine E. Kraus</u> same address as above	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Pulmonary Emphysema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3A</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Unknown</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>6/12</u> ....., <u>19 66</u> to ..... <u>6/20</u> ....., <u>19 66</u> that (I) (we) last saw the deceased alive on ..... <u>6/20</u> ..... <u>19 66</u> and that death occurred at ..... <u>3A</u> M., from the causes and on the date stated above	
<b>22a. SIGNATURE</b> <u>Stephen Lee Magness</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>STEPHEN LEE MAGNESS, M.D.</u>		<b>22b. DATE SIGNED</b> <b>22d. ADDRESS</b> <u>TAYLOR MANOR HOSPITAL</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>6/22/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lakeview Memorial Pk Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Carroll Co., Maryland</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Tichenor &amp; Sons</u> <u>Baltimore, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 08524 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Ellicott City</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>241 Montgomery Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Ellicott City</b> d. STREET ADDRESS <b>117 McAlpine Drvie</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Abbie Parlett</b>					4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>1966</b>						
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 14, 1874</b>		9. AGE (In years last birthday) <b>91</b> yrs. IF UNDER 1 YEAR: Months <b>1</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Howard County</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Edmund Scott</b>					14. MOTHER'S MAIDEN NAME <b>Emily Gamble</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <b>Ralph Parlett</b> Address <b>720 Crestleigh Rd. Ellicott City</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident</b> <b>331X</b> DUE TO (b) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>June 9, 1966</b> to <b>June 24, 1966</b> , that (I) (we) last saw the deceased alive on <b>June 20, 1966</b> , and that death occurred at <b>11:30</b> M. from the causes and on the date stated above.											
22a. SIGNATURE <b>E. P. Williams</b>					22b. DATE SIGNED <b>6/22/66</b>						
22c. PHYSICIAN'S NAME (Type) <b>E. P. Williams</b>					22d. ADDRESS <b>PROFESSIONAL ARTS Bldg BALTO 28</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>June 24, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		23d. LOCATION (City, town or county) (State) <b>Ellicott City</b>					
24. FUNERAL DIRECTOR <b>Harry H. Witzke</b> ADDRESS <b>Columbia Pike Ellicott City Md.</b>					25a. REC'D BY REGISTRAR <b>JUN 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				





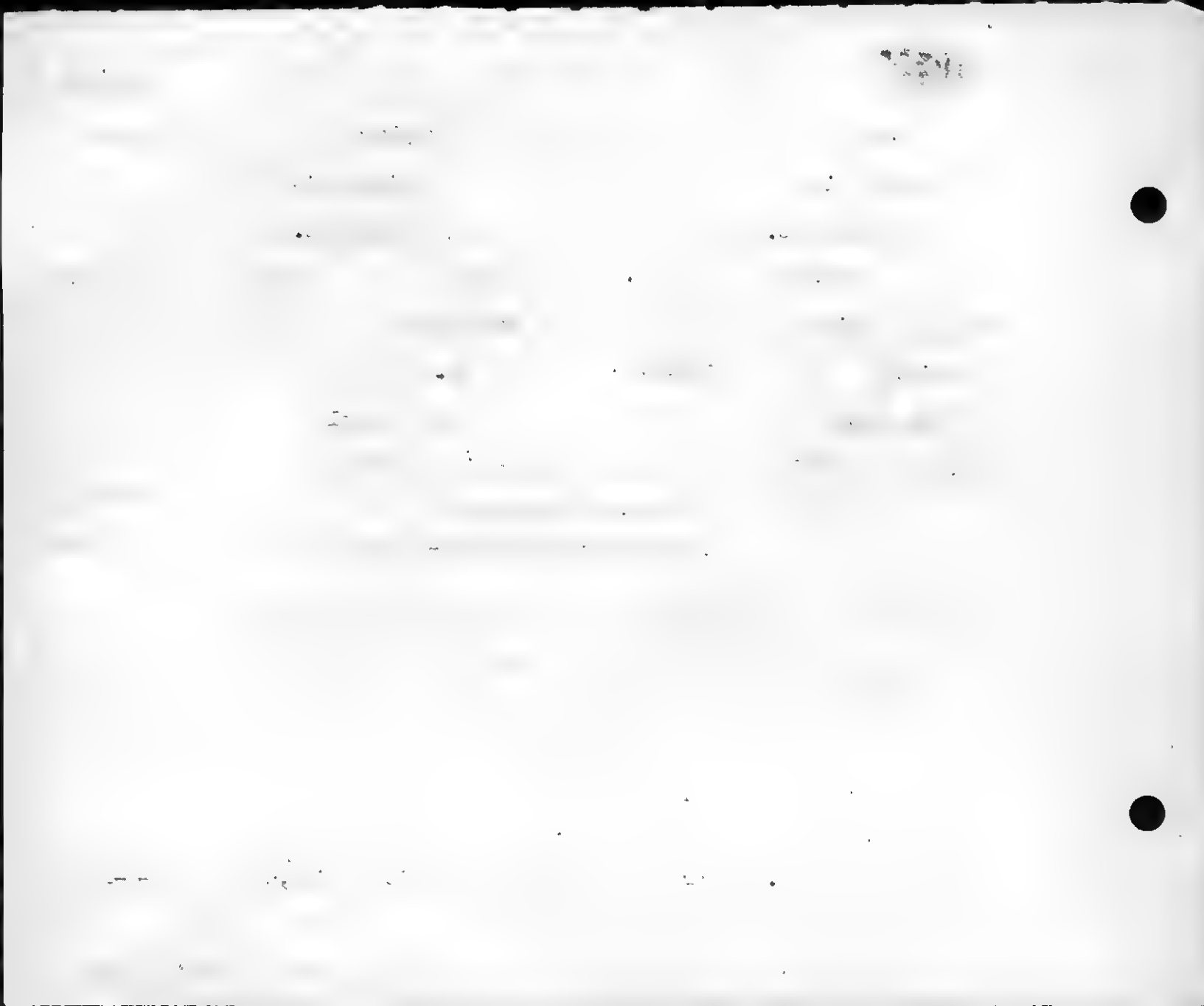
1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
08525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08515

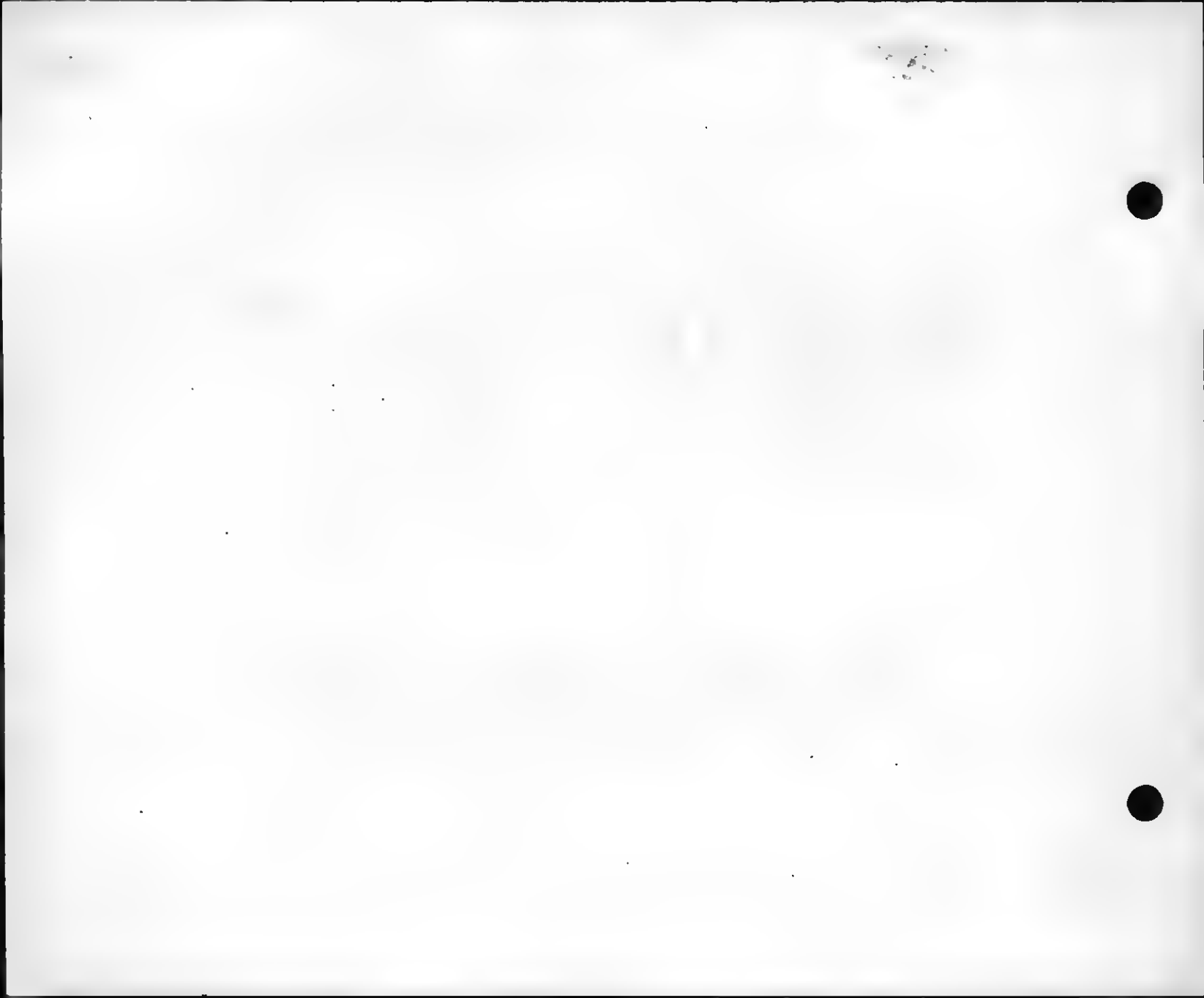
1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>134 College Ave.</b>		e. STREET ADDRESS <b>134 College Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph J. Upman</b>		4. DATE OF DEATH Month Day Year <b>June 5 1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5 1893</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Upman</b>		14. MOTHER'S MAIDEN NAME <b>Anna Bebold</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW1</b>	
17. INFORMANT <b>JULIA UPMAN</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>t201</b> DUE TO <b>Arteriosclerotic cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN INSTANT DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>George E. Burgtorf</b>		22. DATE SIGNED <b>6-6-1966</b>	
EXAMINER'S NAME (Type) <b>George E. Burgtorf</b>		Address <b>Church Road Ellicott City, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6/9/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL</b>	23d. LOCATION (City, town or county) (State) <b>BALTO. MD</b>
24. FUNERAL DIRECTOR <b>F.S. MACNABB</b>		25a. REC'D BY REGISTRAR <b>JUN 7 1966</b>	
ADDRESS <b>301 FREDERICK RD 21228</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penn.</u> b. COUNTY <u>Fayette</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>				c. LENGTH OF STAY IN 1b <u>2 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belle Vernon</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>44 B Pine Tree Road</u>						d. STREET ADDRESS <u>325 Water Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GENEVIEVE MARIE WALTERS</u>						4. DATE OF DEATH <u>June 29 1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25 1912</u>		9. AGE (in years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Burton</u>						14. MOTHER'S MAIDEN NAME <u>Isabelle Watton</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. John B. Walters</u>				Address <u>Belle Vernon Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic cancer of liver</u> <u>170X</u> DUE TO (b) <u>Carcinoma L. Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Adenocarcinoma</u>											
										INTERVAL BETWEEN ONSET AND DEATH: <u>6 weeks</u> <u>2 yrs -</u> <u>2 yrs -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Obesity</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u></u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> , 19 <u>66</u> to <u>6/29</u> , 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>6/29</u> , 19 <u>66</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>J. M. Warren</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/29/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. M. Warren</u>						22d. ADDRESS <u>L. A. UREL Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>July 2, 1966</u>		<u>Belle Vernon</u>		<u>Belle Vernon Pa.</u>					
24. FUNERAL DIRECTOR <u>De Witt Danaedman Laurel Md</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
						DATE <u>JUL 7 1966</u>					



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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6M 1/66

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08527

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08517

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> <b>Baltimore,</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Savage</b>				c. LENGTH OF STAY IN 1b <b>Baltimore - Rural</b> <b>Savage</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>304 Foundry Avenue</b>				d. STREET ADDRESS <b>304 Foundry Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>C.</b> Last <b>WHEELER</b>				4. DATE OF DEATH Month <b>June</b> Day <b>4</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-31-08</b>		9. AGE (In years last birthday) yrs. <b>57</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machine operator earth moving</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Savage Md</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>John N. Wheeler</b>				14. MOTHER'S MAIDEN NAME <b>Eva Cullem</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>212-16-6327</b>		17. INFORMANT <b>Nettie Wheeler Savage Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun wound of head</b> <b>976 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently shot self</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6 -4</b> 19 <b>66</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. (City or town) (County) (State) <b>Baltimore, Howard, Md.</b>							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Rudiger Breiteneker, M.D.</b>				22. DATE SIGNED <b>6/5/66</b>			
EXAMINER'S NAME (Type)				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-6-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Savage Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Savage Howard Md.</b>	
24. FUNERAL DIRECTOR <b>Walt Davidson Laurel Md</b>				25a. RECEIVED BY REGISTRAR <b>JUN 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

5100

1983

James A. Smith



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FOR STATE  
HEALTH DEPT.

08528

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08518

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		c. LENGTH OF STAY IN 1b <b>Frederick</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harmon's Boarding Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOSEPH DOYLE WRIGHT</b>		4. DATE OF DEATH <b>June 26, 1966</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 24, 1884</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>	
11. BIRTHPLACE (State or foreign country) <b>Pikesville, Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-5240</b>	
17. INFORMANT <b>Mrs. Ray T. Fitzwater, Same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic cardio vascular disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Thomas F. Herbert</b>		22. DATE SIGNED <b>6-26-66</b>	
EXAMINER'S NAME (Type) <b>Thomas F. Herbert MD</b>		23. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-29-1966</b>	
23c. LOCATION (City, town or county) <b>Baltimore, Md</b>		23d. (State)	
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Ellicott City, Md</b>		25a. REC'D BY REGISTRAR <b>JUN 28 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE	

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